otherwise provided this Plan, Chapter 28-106, Florida Administrative Code shall be applicable to any administrative proceeding under this Plan.

4. Collection of overpayments or refunds of amounts collected in error will be in accordance with Section 414.41, Florida Statutes and Rule 59G-9.010.

III. Allowable Costs

A. All items of expense shall be included on the cost report which providers must incur in meeting:

1. The definition of nursing facilities contained in Sections 1919(a), (b), (c), and (d) of the Social Security Act.

2. The standards prescribed by the Secretary of HHS for nursing facilities in regulations under the Social Security Act in 42 CFR 483 (2000), Subpart B.

3. The requirements established by AHCA which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610 (2000); and

B. All therapy required by 42 CFR 409.33 (1999) and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapies include physical therapy, audiology, speech pathology and occupational therapy.

C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS-

PUB.15-1 (1993) and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

D. All items of expense, which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. A comprehensive listing of these items is available in the Nursing Facilities Limitations Handbook. The following are examples of expenses that allowable costs for routine services shall include:

(l) All general nursing services, for example: oxygen and related medications, hand feeding, incontinency care, tray service, and enemas;

(2) Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans;

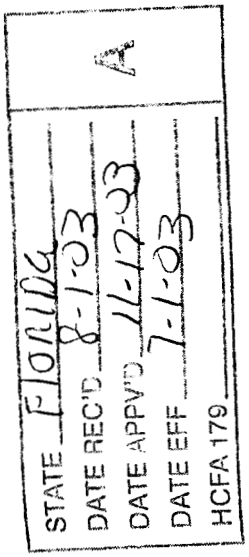
(3) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, adhesive bandages, antacids, aspirin and other non-legend drugs ordinarily kept on hand, suppositories, and tongue depressors;

(4) Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;

(5) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician because these supplements have been classified by the Food and Drug Administration as a food rather than a drug; and

(6) Laundry services other than for personal clothing, prior to October 1, 1993.

(7) Effective October 1, 1993, laundry services, including basic personal



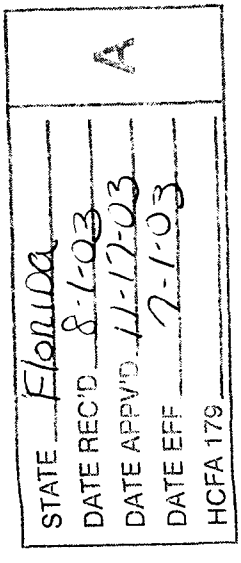
laundry services, but excluding dry cleaning, mending, hand washing or other specialty services, shall be an allowable cost.

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily rate is $34.00; State pays $26.00 and patient is to pay $8.00. If Medicaid patient pays only $6.00, then $2.00 would be an allowable bad debt. All Medicaid Title XIX bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters, etc.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be governed by Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS-PUB.15-1 (1993). Providers shall identify such related organizations and costs in their cost reports.

G. Costs, which are otherwise allowable, shall be limited by the following provisions:

1. The Owner-Administrator and Owner-Assistant Administrator compensation shall be limited to reasonable levels determined in accordance with CMS-PUB.15-1 (1993) or determined by surveyed ranges of compensation conducted by AHCA. The survey shall be of all administrators and assistant administrators of Florida long-term care facilities, and shall, to the extent feasible with the survey data collected, recognize differences in organization, size, experience, length of service, services administered, and other distinguishing characteristics. Results of surveys and salary limitations shall be furnished to providers when the survey results are completed, and survey results shall be updated each year by the wage and salary component of the plan's inflation index. A new salary survey shall be conducted every 3 years.



2. Limitation of rents:

a. For the purposes of this provision, allowable ownership costs of leased property shall be defined as:

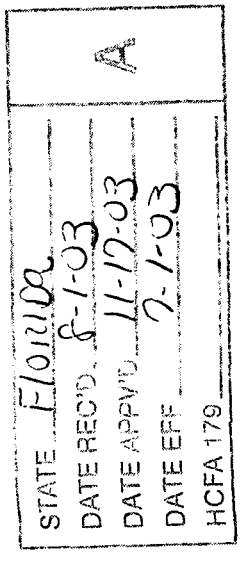
(1) Cost of depreciable assets, property taxes on personal and real property, and property insurance;

(2) Sales tax on lease payments except in cases of related parties; and

(3) Return on equity that would be paid to the owner if he were the provider, as per Section J. below.

b. Lease costs allowed for lease contracts existing as of August 31, 1984 shall remain unchanged except for increases specified in the contract entered into by the lessee and lessor before September 1, 1984. If, prior to October 1, 1985, the lessee exercises an option to renew the lease that existed as of August 31, 1984, increases in lease cost for each year of the renewal period shall be limited to the increase in the Florida Construction Cost Inflation Index (See Appendix B), used for property cost ceiling calculations in Section V., during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over 5 years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.E.1.a.-g. of this plan.

c. (1) For facilities that were not leased as of August 31, 1984 and that are operating under a lease agreement commencing on or after



September 1, 1984 and before October 1, 1985, the Medicaid rent reimbursement shall be based on the lesser of actual rent paid or the allowable ownership costs of the leased property per Section III.G.3.-5.

(2) Annual increases in lease costs for providers in (l) above shall be limited to the increase in the Florida Construction Cost Inflation Index, used for property cost ceiling calculations in Section V, during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over 5 years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.E.1.a.-g. of this plan.

d. (1) Facilities leased on or after October 1, 1985 shall be reimbursed for lease costs and other property costs based on the FRVS per Section V.E.1.a.-g. of this plan. Allowable ownership costs shall be documented to AHCA for purposes of computing the fair rental value.

Facilities not reimbursed based on the FRVS per Section V.E.1.a.- g. of this plan shall not be reimbursed based on the FRVS per Section V.E.1.a.- g. of this plan, solely due to the execution of a lease agreement between related organizations under Section III.F. of this plan.

(2) In no case shall Medicaid reimburse property costs of a provider who is subject to b., c., and d. (1) above and e. below if ownership costs are not properly documented per the provisions of this plan. Providers shall not be reimbursed for property costs if proper documentation, capable of being verified by an auditor, of the owner's costs is not submitted to AHCA. The owner shall be required to sign a letter to AHCA that states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the nursing home properties available to auditors or official representatives of AHCA.

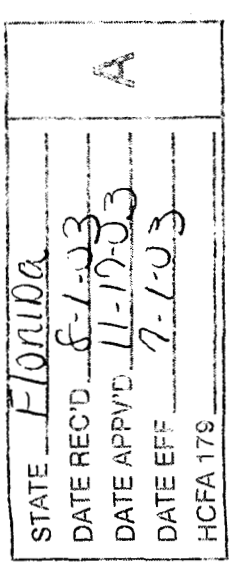
(3) Approval shall not be given for a proof of financial ability for a provider if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (2) above.

e. A lease agreement may be assigned and transferred (assumed) for Medicaid reimbursement purposes if all of the following criteria are met:

(1) The lease agreement was executed prior to September 1, 1984 (when the "limitations of rents" provisions were implemented).

(2) The lease cost is allowable for Medicaid reimbursement purposes.

(3) The lease agreement includes provisions that allow for the assignment.



(4) All provisions (terms, payment rates, etc.) of the lease agreement remained unchanged (only the lessee changes).

When the assumed lease contract in effect on September 30, 1985, expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per Section V.E.1.a.-g. of this plan.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 3b. and 6. below. All provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS-PUB.15-1 (1993) regarding asset cost finding shall be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within 1 year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In a case in which a change in ownership of a provider's or the lessor's depreciable assets occurs, and if a bona fide sale is established, the basis for depreciation shall be the lower of:

1) The fair market value of the depreciable facility as defined by 42 CFR 413.134 (2000) and determined by an appraiser who meets

the requirements of Section 59A-4.103 (6) (I) 9. b. Florida Administrative Code;

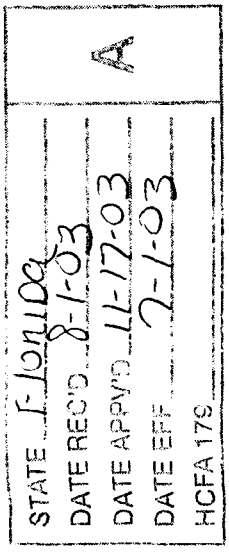
2) The allowable acquisition cost of the assets to the owner of record on July 18, 1984, for facilities operating on that date, or the first owner of record for facilities that begin operation after July 18, 1984; or

3) The acquisition cost of such assets to the new owner.

Example 1: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $1,000,000.00. The new owner's basis for depreciation is the lesser of the two, or $500,000.00.

Example 2: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $300,000.00. The new owner's basis for depreciation is the lesser of the two, or $300,000.00.

4. Limitation on interest expense for property-related debt and on return on equity or use allowance. At a change of ownership on or after July 18, 1984, the interest cost and return on equity or use allowance to the new owner shall be limited by the allowable basis for depreciation as defined per 3.b. above. The new owner shall be allowed the lesser of actual costs or interest cost and return on equity cost or use allowance in amounts that would have occurred based on the allowable depreciable basis of the assets. These limited amounts shall be determined as follows:



a. The portion of the equity balance that represents the owner's investment in the capital assets shall be limited for purposes of calculating a return on equity or use allowance to the total amount allowed as depreciable basis for those assets as per 3.b. above.

b. The amount of interest cost due to debt financing of the capital assets shall be limited to the amount calculated on the remainder of the allowable depreciable basis after reducing that allowable basis by the amount allowed for equity in a. above. The new owner's current terms of financing shall be used for purposes of this provision.

Example 1: The first owner of record after July 18, 1984 has an acquisition cost of $600,000.00. The new owner pays $1,000,000.00 for the facility, makes a down payment of $200,000.00 and finances $800,000.00 at 15 percent for 25 years. The basis for depreciation to the new owner is $600,000.00, and the disallowed portion of the depreciable basis is $400,000.00. Therefore, the allowable equity attributable to investment in the capital assets is $200,000.00, and interest cost allowed shall be computed on $400,000.00 ($600,000.00 minus $200,000.00) at 15 percent over 25 years.

Example 2: If the new owner above had made a down payment of $700,000.00 and financed $300,000.00, the allowable equity would be $600,000.00, and no interest cost would be allowed.

5. Costs attributable to the negotiation or settlement of a sale or purchase of a facility occurring on or after July 18, 1984 shall not be considered allowable costs for Medicaid reimbursement purposes to the extent that such costs were previously reimbursed for that facility under a former owner. Such costs include

legal fees, accounting fees, administrative costs, travel costs, and costs of feasibility studies, but do not include costs of tangible assets, financing costs, or other soft costs.

6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	**Example 2**
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

H. Recapture of depreciation resulting from sale of assets.

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement, indicates the fact that depreciation used for the purpose of computing allowable costs was greater than